

## California's Health Benefit Exchange Legislation

Summaries of AB 1602 (Perez) and SB 900 (Alquist & Steinberg) August 24, 2010

Implementation of federal reform brings unprecedented opportunity to improve the health insurance system in California. At the core of this prospect is the emergence of state-and regional-based health insurance exchanges. In the exchanges, individuals with incomes between 133-400% of poverty will receive refundable tax credits in order to purchase private health insurance and will pay affordable sliding-scale premiums capped at 2% - 9.5% of income. Small employers will also be able to participate in the exchanges, and low-wage small businesses can receive tax credits up to 50% of the employer share of premium. Based on the data of the UCLA Center for Health Policy Research, the California exchange will ultimately subsidize up to 45% of individuals purchasing private insurance and cover 2.3 million of our uninsured.

The federal reform law requires states to have fully functioning exchanges by January 2014. It specifies that the exchanges offer coverage for individuals and small businesses, and that it be operated by a government agency or non-profit entity. Health plans must adhere to the exchange guidelines in order to offer subsidized coverage through the Exchange. Purchase of insurance through the exchanges will be available for U.S. citizens and legal permanent residents. The exchanges will also contain new consumer protections to which health plans must adhere in order to take advantage of the new market.

Because of the scope and importance of the **California Health Benefit Exchange**, the California legislature has moved forward to initiate the exchange this year and begin its construction in January 2011. Two pieces of legislation, AB 1602 (Perez) and SB 900 (Alquist & Steinberg), recently passed out of the legislature and are on the Governor's desk awaiting his signature (or veto). The governance and structure of the Exchange are set forth in SB 900. Requirements on participating health plans and other insurance market regulatory changes are in AB 1602. Each bill is contingent on the other being signed, so both have to be signed for the design to take affect. Below are summaries of the two bills as they were passed:

## Senate Bill 900 (Alquist & Steinberg)

• The exchange will be an independent public entity not affiliated with any one agency or department. It will be financed almost entirely from fees imposed on participating health plans and will be free from the requirement of an annual budget appropriation.

- The exchange will be governed by five-member board of directors. The board will be comprised of the Secretary of California Health and Human Services (or his/her designee), two members appointed by the Governor, one member appointed by the Senate Rules Committee, and one member appointed by the Speaker of the Assembly.
- Members of the board must be California residents and shall serve for four-year terms. 
  Members must have demonstrated expertise in at least two of these areas: the health care

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<sup>&</sup>lt;sup>1</sup> Except that the initial appointment by the Senate Committee on Rules shall be for a term of five years, and the initial appointment by the Speaker of the Assembly shall be for a term of two years.

- coverage market, the small group health care coverage market, health benefits plan administration, health care finance, administering a public or private health care delivery system, or health plan purchasing.
- There are strict conflict-of-interest disqualifications for potential board members. One may not be a member of the board if he or she is employed by, a consultant to, a member of the board of, or affiliated with a carrier or other insurer, an agent or broker, a health care provider, a health care facility, a health clinic, or a trade association of carriers.
- Members of the board will not be paid for their service.
- The board must apply for grants available under federal health reform that allow for federal funding to establish the exchange prior to 2014.
- The exchange will be headed by an executive director and run by staff who will not be subject to civil service requirements. The executive director will serve at the pleasure of the board.
- The director, in coordination with the California Insurance Commissioner, will review the health reform "Internet Portal" developed by the United States Secretary of Health and Human Service to determine whether it provides sufficient information regarding all health benefit products offered by plans and insurers in the individual and small employer markets in order to facilitate fair and affirmative marketing of all individual and small employer plans products, particularly outside the exchange.

## **AB 1602 (Perez)**

- It is the intent legislature that exchange be implemented in accordance with federal health reform and, in doing so, it:
  - Reduces the number of uninsured Californians by creating a marketplace for Californians to purchase affordable, quality health care coverage;
  - Strengthens the health care delivery system;
  - Guarantees availability and renewability of coverage for individuals and small businesses; and
  - Requires that plans and insurers issuing coverage in the individual and small employer markets compete on the basis of price, quality, and service, and not on risk selection.
- The exchange will be an active purchaser of health plans. It will establish and use a competitive process to select participating carriers.
- The board will determine the minimum requirements a health plan must meet to be considered for participation in the exchange as a "qualified health plan" and implement procedures of the certification, recertification and decertification of qualified health plans.
- In order to support the development, operations, and management of the exchange, the board will assess a reasonable charge on the qualified health plans.
- The board shall require plans in the exchange to:
  - Submit justifications for any premium increase prior to implementation of the increase. The plans shall prominently post that information on their web sites;

- Make available to the board and public: claims payment policies and practices, periodic financial disclosures, data on enrollment, data on disenrollment, data on the number of claims that are denied, data on rating practices, information on cost sharing and payments with respect to any out-of-network coverage, and information on enrollee and participant rights;
- o Immediately notify the exchange when an individual is or will be enrolled in or disenrolled from any qualified health plan offered by the carrier;
- Offer at least one product at each level of five tiers of coverage (platinum, gold, silver, bronze, catastrophic) in each region of the state; and
- Offer all of the products outside the exchange and inside as well.
- The exchange will use a standardized format for presenting health benefit options in the exchange.
- The exchange will establish uniform billing and payment policies for qualified health plans offered in the exchange to ensure consistent enrollment and disenrollment activities for individuals enrolled in the exchange.
- The exchange will assign a rating to each qualified health plan.
- The exchange will inform individuals of eligibility requirements for Medi-Cal, Healthy Families or any applicable state or local public program, and if the exchange determines that an individual is eligible for any such program, enroll that individual in the program.
- The board will develop processes to coordinate with the county entities that administer eligibility for Medi-Cal and the entity that determines eligibility for Healthy Families.
- The exchange will determine eligibility, enrollment, and disenrollment criteria for enrollees and potential enrollees, and coordinate that process with all other state departments and agencies.
- The board shall operate a toll-free hotline to respond to requests for assistance.
- The board will undertake activities necessary to market and publicize the availability of health care coverage and federal subsidies through the Exchange.
- The board may:
  - Collect premiums and assist in the administration of subsidies;
  - Collaborate with the DHCS and MRMIB to allow an individual the option to remain enrolled with his or her carrier and provider network in the event the individual experiences a loss of eligibility of premium tax credits and becomes eligible for the Medi-Cal program or the Healthy Families Program; and
  - Make available supplemental coverage for enrollees of the exchange to the extent permitted by federal reform, provided that no state money is used to subsidize the cost of that coverage.
- The board shall establish an appeal process for prospective and current enrollees of the exchange that complies with all requirements of the federal reform concerning the role of a state exchange in facilitating federal appeals of exchange-related determinations.
- The exchange will maintain a website for enrollees and prospective enrollees to obtain standardized and comparative information about health plans.

- The exchange shall develop an electronic calculator to determine the actual cost of coverage after the application of any premium tax credit and any cost-sharing reduction under health reform.
- The exchange will establish the "Navigator Program" and ensure that navigators conduct public outreach and education, distribute fair information, facilitate enrollment, and provide referrals in ways that are culturally and linguistically literate.